Ear, Nose & Throat Consultants of East TN
History and Systems Review Form

Date: _____
Age: _____
Date of birth: _____

For Office Use Only:
FS # _____
PW# _____
HM# _____
LC# _____

Name:(Last) _____ (First) _____ (Middle)_____

***Drug Allergies*: Yes / No If yes, list all:**

***Circle all Prior Surgeries*:**

Heart Surgery	Gallbladder Removal
Sinus Surgery	Appendectomy
Ear Surgery	Hernia Repair
Back Surgery	Skin Cancer Removal
Tonsillectomy	Adenoids Removed
Other:	Ear Tubes

_____

***Family History:* Any Significant Illnesses?**

Mother:	Father:	Siblings:
_____	_____	_____
_____	_____	_____
_____	_____	_____

***Medical History*:**

Diabetes	Yes / No
Hypertension	Yes / No
Heart Trouble	Yes / No
Cancer	Yes / No
Stroke	Yes / No
Arthritis	Yes / No
Bruising/Bleeding	Yes / No

Other Health Problems:

***Social History*:**

Tobacco Use:
Have you ever smoked? Yes / No Packs / day_____

How Long_____ If quit smoking, how long ago?_____

Alcohol Use: ____drinks / ____day, ____wk, ____month

Illicit Drug Use: _____How often_____

Occupation: _____

If patient is a child, is he/she in Daycare? Yes / No

***Review of Systems*: Please circle any problems you are presently experiencing or have previously experienced:**

Good Health	Yes / No	Shortness of Breath	Mouth Sores
Recent Weight Change		Cough	Dental Problems
Fatigue		Chest Pain	Painful Breathing
Hearing Loss		Neck Stiffness	Spitting up blood
Ringing in Ears		Dizziness	Seizures
Earache or Drainage		Difficulty Swallowing	Numbness
Nose Bleeds		Vocal Hoarseness	Enlarged Lymph Nodes
Sore Throat		Sinus Problems	Bad Breath or Bad Taste

***Medications: Please list all medications you are taking, including over-the-counter medications*:**

Medication:	*Dosage:*	*How Often:*	*Who Prescribed:*	*(In office use)*